

Statement of
Robert H. Roswell, M.D.
Under Secretary for Health
Department of Veterans Affairs
Before the
Subcommittee on Health
Committee on Veterans Affairs
U. S. House of Representatives

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Mr. Chairman, members of the subcommittee, and other members of the Missouri and Kansas Congressional Delegations,

I thank you for the opportunity to bring you up to date on the actions taken to correct environmental concerns at the Kansas City VAMC. I will begin by sharing information about the situation that brought us together today, recap findings from the OIG and other reports, share with you actions already taken and discuss my actions for assuring that situations such as this do not happen again, anywhere in the VA Healthcare System.

What is now known is that there was, over time, a general deterioration in the cleanliness of the environment at the KC VAMC. This was brought to national attention when an article appeared in the Archives of Internal Medicine in March of this year. The article attempted to relate an infestation of rodents in a distant part of the medical center to the presence of Nasal Myiasis (commonly known as maggots) in two patients in the Medical Intensive Care Unit. Despite the author's assertions of a relationship between the rodents and flies, there was (and is) no conclusive evidence that such a relationship existed. Most probably the Myiasis was due to gravid flies entering the MICU through construction barriers. The article did, however, incidentally depict the Kansas City

VAMC as a dirty hospital and it quite explicitly identified a number of general cleanliness issues.

This led to several immediate actions on the part of the Secretary of Veterans Affairs and my office. The Inspector General was asked to dispatch a team to the medical center to conduct an in-depth audit, the Network Director and Deputy Network Director were detailed to other assignments pending the audit, and an Acting Network Director, Ron Norby, was appointed to lead a remedial effort at Kansas City and provide leadership for the overall Network.

The Office of the Inspector General has completed his report and has found that the Kansas City VAMC was not maintained at appropriate levels of cleanliness nor was there an adequate pest control program. These conditions existed since at least 1997 and they were known by both Medical Center and Network management.

Overall, there was a lack of effective supervision and leadership in the housekeeping department. A decision was made by the prior Medical Center Director not to fill the Environmental Program Manager position until recently and it had been vacant since 1997. Front-line supervisory positions were also eliminated and the facility failed to hire the numbers of housekeeping staff necessary to maintain the cleanliness of the facility. In addition, there were significant deficiencies in the engineering maintenance staffing that resulted in delayed response to minor and preventive maintenance projects.

Due to the lack of knowledgeable leadership and supervision, the infrastructure within the housekeeping department eroded. There was no formal training program for new housekeepers and no ongoing continuing education for existing staff, no effective quality assurance program, no performance feedback related to the adequacy of housekeeping services and no routine cleaning schedules and assignments necessary to maintain the facility. Very importantly, the pest-control contractor was not adequately supervised and the quality of services was not effectively monitored. This led to unacceptable levels of rodent and insect control.

Equipment for housekeeping was also inadequate and/or non-existent to meet the needs of the facility. For example, even though the hospital had carpeting in many locations, there was no carpet cleaning equipment. In addition, the housekeeping and

cleaning duties and responsibilities among departments were not well defined. This was especially true between the medical center and the canteen service.

All of these deficiencies were further exacerbated by the fact that the facility is housed in a building that is 50 years old. Many of the materials and finishes were outdated, inadequate and unattractive. There was no overall interior design plan or systematic plan for preventative maintenance, painting and refurbishment. Lighting throughout corridors was dim and outmoded, which impacted on the overall appearance of the facility. From the IG report, it is clear that Medical center and Network management were aware of these issues and shortcomings. The VAMC did not take the necessary steps to stop the ongoing erosion of cleanliness and the gradual overall degradation in the cleanliness of the medical center.

I am, however, very pleased to report that despite all this, the quality of care provided to veterans at the Kansas City VAMC has remained high. At Town Hall and other meetings of veterans, stakeholders and staff over the past two months, veterans have repeatedly relayed their high level of satisfaction with the care provided at the medical center. The IG report confirmed that the overall quality of care is excellent. I attribute this to the outstanding, dedicated and hard working staff at this facility who have given their talented expertise to serve the health care needs of veterans.

I have just described the situation as it existed roughly two months ago. Since then, an extremely aggressive action plan has been developed to correct the identified deficiencies and to assure that the facility, once it is brought back up to a high standard of cleanliness, is maintained at that level. I am pleased to report that this action plan is well on its way to being implemented and the results are already dramatically apparent as you walk through this medical center. Mr. Hill, the newly appointed Medical Center Director will, in his testimony, describe the plan and accomplishments that have already been achieved. I will therefore not offer further comment in this area except to say that I believe that the plan is comprehensive, addresses the issues identified by the IG and others and, when completely implemented, will once again make this medical center a showplace for cleanliness.

I would like to share with you several actions that the Secretary and my office have taken to assure that this situation does not occur elsewhere in the VA Healthcare System. First, we have asked all facilities to review their physical plants, the cleanliness of their facilities and their pest control programs and certify, in writing, that they are being properly maintained. This certification has been concurred on, in writing, by each Network Director. I have asked all facilities to assure that their senior leaders are conducting regular weekly environmental rounds and that they have mechanisms in place for rapidly addressing issues and environmental deficiencies when they are noted. I have also asked Network Directors to conduct environmental rounds at each facility when they visit to assure that local managers are indeed attending to these issues. Further, I am incorporating the expectation for maintaining facilities into the performance measures for Network and facility directors this next year. Finally, I have asked the VHA Office of Performance to closely monitor and trend all reports from accrediting bodies, review groups (including the IG) and others and to track what actions are taken to correct deficiencies. The senior staff in my office will review these reports frequently and provide appropriate counseling and follow-up with managers having accountability for remedial activities.

Secretary Principi, in a personal discussion with all VHA Network managers and through follow-up correspondence, made it clear that managers will be held personally accountable for correcting deficiencies in their facilities when they are noted and when they are under their control. I also feel it is important to hold managers accountable for maintaining their facilities. In recognition of the gravity of this situation and the potential for new information to arise during today's hearing, the Department has deferred initiating action regarding top management officials until the hearing proceedings are completed. The Department intends to conclude its review in the near future.

In summary, the cleanliness and environment for care was allowed to deteriorate unacceptably at the Kansas City VAMC over the past several years. An aggressive action plan has been developed that I am convinced will bring the facility back to a superior level of cleanliness. I have full confidence in the leadership Mr. Hill brings to the facility and know that he and his team will work tirelessly to complete corrective actions and to maintain the cleanliness of this facility in the future. I am particularly

pleased that the quality of care has been high at the Kansas City VAMC and I am confident that it will remain high. It is an honor to serve the veterans of this community and they deserve nothing less than a facility that provides the highest quality of care in a clean, safe environment.

Thank you for the opportunity to come before you today. I would now like to ask Mr. Hill to further discuss the actions that have already been taken and those planned to rebuild the environment of care at the Kansas City VAMC.